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Please access the **Injury Reporting Procedure** page on the Safety Services website.

http://safetyservices.ucdavis.edu/article/injury-reporting-procedure

Complete the electronic *Employer's First Report (EFR)* as soon as practicable.

UCD Employer's Report of Occupational Injury or Illness

UNIVERSITY POLICY REQUIRES THAT INDUSTRIAL INJURY/ILLNESS BE REPORTED TO WORKERS' COMPENSATION WITHIN 24 HOURS OF OCCURRENCE AND STATE REGULATIONS REQUIRE THAT ALL ACCIDENTS BE INVESTIGATED.
In the event of a serious injury or hospitalization, call Workers' Compensation immediately at (530) 752-7243. This form must be completed in its entirety and mailed or faxed (530) 752-3439 to Workers' Compensation. Omission of information could result in a delay of benefits.

EMPLOYEE MUST COMPLETE THESE SECTIONS:

EMPLOYEE DATA

Employee Name:		Employee's UCDavis ID #:
Address:		Home Phone: ( )
City/State/Zip:	Sex: ☐Female ☐Male	Date of Birth:
Department/Location:		Employee's Work Phone: ( )
Payroll Title/TC:	Date of Hire:	Annual Gross Salary: $
Supervisor's Name:	Supervisor's Work Phone: ( )	
Employee ( ) Volunteer ( ) Student-Employee ( )	( )hours per day	( ) days per week ( ) total weekly hours

EMPLOYEE STATEMENT

Specific Injury/Illness/Exposure:	Body Part(s) affected:	Date of injury/illness:
Location where injury or illness occurred:		Others Injured? ☐Yes ☐No
What equipment, materials or chemicals caused the injury/illness? :		Who witnessed this injury?

Explain in detail how the injury occurred. Include specific activities/tasks performed at the time.

Medical Treatment provided by:
___Employee Health Services ___Sutter Davis Hospital ER Other: (Provide Name &Phone #) _____
___Private Physician ___UC Davis Medical Center _____
___First Aid, no medical care needed.

Employee Signature: Today's Date:

EMPLOYER'S INVESTIGATION AND STATEMENT (EMPLOYER COMPLETES):

EMPLOYER

After the investigation, explain in detail how the injury/illness occurred and the specific activity being performed:

What was the injury, illness or exposure?

INITIAL CAUSE	CONTRIBUTING FACTORS AND ACTIVITIES		PREVENTIVE ACTIONS
☐ Struck by or against object (indicate) _____	**Equipment** ☐ Equipment failure ☐ Equipment unavailable ☐ Improper equipment or material used for job	☐ Ventilation issues ☐ Ergonomic factors **Employee** ☐ Physically not able to do work ☐ Employee fatigue ☐ Unbalanced or poor position or motion ☐ Incorrect procedures used for task ☐ Other unsafe practice	**SUPERVISOR WILL:** ☐ Develop/revise safety procedures and update IIPP or Chem. Hyg. Plan ☐ Request ergonomic evaluation ☐ Order new equipment ☐ Order new personal protective equipment ☐ Remove equipment from use and repair/replace ☐ Schedule preventive maintenance ☐ Will retrain employee before task is re-assigned. ☐ Perform on-site review of work activity, update job safety analysis. ☐ Reconfigure work area ☐ Communicate corrective actions to others in job category. ☐ Other_____ _____
☐ Caught in/under/ between	**Personal protective equipment** ☐ Not worn ☐ Not readily available ☐ Not adequate for the task ☐ Personal protective equipment failure	**Assistance** ☐ Difficult to perform task without help ☐ Safety features or devices not readily available ☐ Assistive devices not used	
☐ Fall / Slip / Trip	**Training/Experience** ☐ Lack of training ☐ Safety training provided, not followed ☐ New task for employee or lack of experience	☐ **Lack of policy/procedure** ☐ **Animal** (explain below) ☐ **Other** (explain) _____ _____ _____ _____	**Preventive actions will be completed by:** Name_____ Expected date of completion_____
☐ Material handling or lifting	**Work Area** ☐ Work area set up improperly ☐ Inadequate lighting or noise issues ☐ Housekeeping issues ☐ Environmental factors (rain, wind, temp., etc)	**Use additional pages as needed**	
☐ Repetitive motion			
☐ Chemical exposure			
☐ Body fluid exposure: __Needle stick __Sharps			
☐ Animal bite			
☐ Other, Explain _____ _____ _____ _____ _____			

SUPERVISOR'S OR MANAGER'S SIGNATURE: **Date of Investigation:**

DEPARTMENT HEAD'S SIGNATURE: **Date:**

PLEASE NOTE: COMPLETING THIS FORM IS NOT AN ADMISSION OF UNIVERSITY LIABILITY 7/2011 ER: WC/H/MJB

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